STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of [redacted]	**FINAL DETERMINATION AND ORDER AFTER HEARING**
Pursuant to § 494 of the Social Services Law	**Adjud. Case #:** [redacted]

The attached Recommended Decision After Hearing (Recommended Decision) is incorporated in its entirety including but not limited to the Findings of Fact, Conclusions of Law and Decision section.

ORDERED: The attached and incorporated Recommended Decision in its entirety is hereby adopted by the Executive Director.

ORDERED: The Vulnerable Persons' Central Register shall take action in conformity with the attached Recommended Decision, specifically the Decision section.

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

Dated: August 22, 2017
Schenectady, New York

David Molik
Administrative Hearings Unit

CC. Vulnerable Persons' Central Register
Administrative Appeals Unit
[redacted], Subject
Dennis Gaughan, Esq.

STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS

In the Matter of the Appeal of

[redacted]

Pursuant to § 494 of the Social Services Law

RECOMMENDED DECISION AFTER HEARING

Adjud. Case #: [redacted]

Before: Mary Jo Lattimore-Young
Administrative Law Judge

Held at: New York State Justice Center for the Protection of People With Special Needs
Administrative Hearings Unit
2630 North America Drive
West Seneca, New York 14224
On: [redacted]

Parties: New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Theresa Wells, Esq.

[redacted]
By: Dennis Gaughan, Esq.
6161 South Park Avenue
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JURISDICTION

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [redacted] (the Subject) for neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report dated [redacted], [redacted] of neglect by the Subject of a Service Recipient.

2. The Justice Center substantiated the report against the Subject. The Justice Center concluded that:

Allegation 1

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to provide proper supervision, during which time a service recipient left the room unnoticed and sustained injuries.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

Allegation 2

It was alleged that on [redacted], at the [redacted], located at [redacted], while acting as a custodian, you committed neglect when you failed to provide adequate services by not following the head injury protocol when a service recipient was found on the floor.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

3. An Administrative Review was conducted and as a result the substantiated report was retained.

4. The facility, located at [redacted], is an Individualized Residential Alternative (IRA) that provides day habilitation services for developmentally disabled individuals, and is operated by the New York State Office for People With Developmental Disabilities (OPWDD), which a provider agency that is subject to the jurisdiction of the Justice Center. (Hearing testimony of the Justice Center Investigator [redacted], hereinafter referred to as the Justice Center Investigator)

5. At the time of the alleged neglect, the Subject was employed at the facility as a Habilitation Specialist 1 (Hab Spec 1) responsible for the direct care and supervision of the service recipients assigned to the program classroom that he was scheduled to supervise. The Subject was trained on the Service Recipient's treatment plans. On [redacted], the Subject received "Falls and First Aid" training that covered the facility's head injury protocols applicable to all staff. To follow the protocol, staff were required to perform a series of checks of the service recipient to be undertaken at different stages to assess whether a service recipient had sustained trauma or a blow to the head/face. Under the protocol stages, staff was required to act and initiate the primary "survey" process to detect whether a service recipient has been injured. The primary survey steps required staff to check the service recipient's airway, breathing, circulation and observe the individual for signs of a spinal disability. If necessary, then staff was to begin immediate first aid, monitor vital signs, observe then monitor for forty-eight hours and document the incident by describing the injury and how it occurred. The Subject was a custodian as that term is so defined in Social Services Law § 488(2). (Hearing testimonies of the Subject and Staff 1; Justice Center Exhibits 6 and 32-33, 46 and 48, audio interviews of the Subject, Staff 1 and Staff

2)

6. At the time of the alleged neglect, the Service Recipient was a non-verbal fifty-seven-year-old female who communicated by using gross vocalizations, facial expressions and a few manual signs. The Service Recipient could follow simple familiar directions. Although the Service Recipient was independently ambulatory, there were times when staff needed to assist her when she had difficulty ambulating on stairs because of her poor depth perception. (Hearing testimony of the Justice Center Investigator; Justice Center Exhibits 6, 9-10 and 30)

7. The Service Recipient resided at the [redacted] and was transported back and forth from her residence to the facility's day habilitation program each weekday. The Service Recipient was transported by the [redacted], an independent bus service. The Service Recipient had diagnoses of profound intellectual disability, osteoporosis/osteopenia, seizure disorder and other medical conditions. Per the Service Recipient's Plan of Protective Oversight (POPO), while she is at day habilitation program, staff was required to provide periodic observations of her every five minutes. The Service Recipient's POPO and her [redacted] Plan of Nursing Supervision (PONS) stated that, due to her history of osteoporosis/osteopenia, any falls were required to be reported to the nurse. (Justice Center Exhibit 30) The Service Recipient's treatment plans did not list any behavioral history of her sitting on or dropping to the floor. The Subject was trained in the Service Recipient's treatment plans and knew that the Service Recipient liked to wander around the room to close open doors. (Hearing testimonies of the Subject, Staff 1 and the Justice Center Investigator; Justice Center Exhibits 6, 9-10, 30-31 and 48)

8. On [redacted], the Subject was assigned as the Hab Spec 1 in the Service Recipient's day habilitation program (room #[redacted]). The Subject's co-workers were Staff 1, a

Licensed Practical Nurse (LPN) and Staff 2, a Direct Support Assistant (DSA).[1] At that time, facility policy was that staff were equally responsible to supervise all the service recipients assigned to their program rooms. Program room #[redacted] was an open classroom where all activities were held, including lunch. There was only one door to room #[redacted], which door led to an indoor hallway. (Hearing testimony of the Subject and Staff 1; Justice Center Exhibits 6, 32, 48 and 49)

9. Sometime early on the that morning of [redacted], the Service Recipient was transported to her day facility habilitation program by [redacted]. Transportation staff noticed that the Service Recipient entered the bus without any problems. When the Service Recipient arrived to program that morning, the Subject and Staff 2 were already in room #[redacted] providing supervision to the service recipients. At various times throughout the day, Staff 1 left room #[redacted] to perform her medication administration/documentation duties in different parts of the building. Staff 1 notified the other staff each time she had to depart from the room. (Hearing testimonies of the Subject and Staff 1; Justice Center Exhibits 6, 16, 32 and 48)

10. At about 2:00 p.m., the Subject noticed the Service Recipient in the room sitting on a couch while the Subject attended to a different service recipient who had cut his finger. Staff 1 had previously left the room to retrieve first aid supplies and perform medication administration duties. Staff 2 had also left the room earlier to work in a different area of the building. During this time, the Subject was left in the room alone with the Service Recipient and apparently five other service recipients. (Hearing testimonies of the Subject, Staff 1 and the Justice Center Investigator; Justice Center Exhibits 6, 32 and 48, audio interview of the Subject, Staff 1 and Staff 2)

11. Shortly thereafter, while the Subject was continuing to attend to the injured service

[1] Hereinafter [redacted], a LPN and [redacted] is referred to as Staff 1. [redacted], a DSA is hereinafter referred to as Staff 2.

recipient, the Service Recipient left the room unnoticed by the Subject and fell in the hallway near room #[redacted]. (Hearing testimonies of the Subject, Staff 1; Justice Center Exhibits 6, 32 and 48, audio interviews of the Subject, Staff 1 and Staff 2)

12. Sometime about 2:10 p.m., Staff 2 was walking down the hallway on his way out of the building. Staff 2 discovered the unsupervised Service Recipient sitting on the floor in the hallway near room #[redacted] with her back against the wall. Staff 2 assisted the Service Recipient from the floor to a standing position, and then escorted her to room #[redacted] where the Subject was the only staff person in the room at that time. Staff 2 reported to the Subject that he found the unsupervised Service Recipient sitting on the hallway floor outside of room #[redacted]. (Hearing testimonies of the Subject, Staff 1 and the Justice Center Investigator; Justice Center Exhibits 6, 13 and 48, audio interviews of the Subject, Staff 1 and Staff 2)

13. The Subject admittedly did not conduct a body check, notify the nurse or follow the head injury protocol. He also did not report the incident or document that the Service Recipient had eloped from the room. (Hearing testimonies of the Subject, Staff 1 and the Justice Center Investigator; Justice Center Exhibits 6, 13 and 48, audio interviews of the Subject, Staff 1 and Staff 2)

14. After being returned by Staff 2 to room #[redacted], the Service Recipient engaged in her usual activities. At the end of program, Staff A escorted the Service Recipient outside to her bus, at which time she walked onto the bus independently and then was transported to her residence. (Hearing testimony of Staff A and Justice Center Exhibits 6, 15-16 and 48)

15. Upon returning to her residence, when the Service Recipient exited the bus, the

[redacted] Monitor[2] and the residential staff DSA,[3] noticed that when the Service Recipient exited the bus, she did not use her right arm to hold onto the railing as she usually did when walking down the bus steps. Thereafter, when the DSA escorted her inside of the residence and into the bathroom, the DSA noticed that the Service Recipient did not use her right arm to pull her pants down. Staff then visually checked the Service Recipient and observed that her right arm appeared to be "slightly swollen," that she had a lump the size of a "goose egg" on her right temple and a small laceration above the right eyebrow. Staff also observed that the Service Recipient could bend her right arm at the wrist and elbow but did not appear to be in any discomfort.

16. The facility's registered nurse (RN) was immediately notified. The RN took the Service Recipient's vital signs, conducted a full body check and confirmed staff's findings from their visual body check. The RN determined that the Service Recipient required medical attention and that the head injury protocol needed to be followed. The Direct Assistant 1 (DA 1) was notified and took the Service Recipient to an urgent care center where she was examined and x-rays were taken. The Service Recipient was diagnosed with a hematoma on the right side of the forehead, a fractured humerus bone in her right arm. She was provided with a sling to immobilize her arm. The Service Recipient was then referred that same day to a hospital for further treatment. At the hospital, the Service Recipient was seen by an orthopedic surgeon who did not recommend surgery at that time. (Justice Center Exhibits 6, 11, 20, 22-25 and 48, an audio recording of interviews of the [redacted] Monitor and the residential staff DSA)

17. On the date of the incident, the Service Recipient did not fall or sustain any injuries while being transported to or from the day habilitation facility. (Justice Center Exhibits 6 and 48,

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[2] [redacted] was the [redacted] Monitor, hereinafter referred to as the transportation monitor.
[3] [redacted] was the residential staff DSA who observed the Service Recipient exiting the bus after she returned from day habilitation program.

an audio recording of interviews of the [redacted] Monitor and the residential staff DSA)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute abuse and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. (SSL § 492(3)(c) and 493(1) and (3)) Pursuant to SSL § 493(3), the Justice Center determined that the initial report of neglect presently under review was substantiated. A "substantiated report" means a report "… wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred…" (Title 14 NYCRR 700.3(f))

The neglect of a person in a facility or provider agency is defined by SSL § 488(1)(h) as:

> "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through (g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a

> duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 3, which is defined under SSL § 493(4) (c) as follows:

> Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject(s) committed the act or acts of abuse and/or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged abuse and/or neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse and/or neglect by a preponderance of the evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of the evidence that the Subject committed an act, described as "Allegation 1" and "Allegation 2" in the substantiated report.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-49) The investigation underlying the substantiated report was conducted by the Justice Center Investigator, who was the only witness

who testified at the hearing on behalf of the Justice Center. Although the Service Recipient was interviewed during the investigation, she was unable to provide any information.

The Subject testified at the hearing in his own behalf. Staff 1 also testified in her own behalf. No other evidence was provided.

In this case, the Justice Center has proved by a preponderance of the evidence that the Subject breached his duty to the Service Recipient and committed the neglect alleged.

Allegation 1

The Justice Center contends that on [redacted], the Subject failed to provide proper supervision, during which time the Service Recipient left the room unnoticed and sustained injuries.

To sustain an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty, and that her breach either resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (SSL § 488(1)(h))

Specifically, the evidence establishes that the Service Recipient's POPO required supervising staff to conduct checks of the Service Recipient every five minutes. The Subject was assigned to room #[redacted], which was the Service Recipient's program room. At 2:00 p.m., the Subject noticed the Service Recipient sitting in the room on a couch. By 2:10 p.m., Staff 2 returned the Service Recipient to the room and told the Subject that he found her unsupervised and sitting on the floor in the hallway outside of the room. The Subject admittedly did not conduct a body check of the Service Recipient for potential injuries. The Subject did not notify the nurse or anyone else about the incident. The Subject also did not document the fact that the Service Recipient left the

room for a period of time. (Hearing testimony of the Subject)

The Subject had a duty to properly supervise the Service Recipient per her POPO, which required five-minute periodic visual checks. The Subject breached that duty when he failed to properly perform the required observations, resulting in the Service Recipient being allowed to elope from the room unsupervised, then falling and breaking her right arm. Although the Subject was not cited for his failure to properly document the Service Recipient's elopement, the Subject should have done so in the event that this information was needed to implement changes to her treatment plans.

Consequently, the Subject's conduct resulted, or was likely to result in, physical injury, or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. The Subject's failure to properly supervise resulted in the Service Recipient sustaining a broken right arm, an injury to her right temple and a small laceration above her right eyebrow. The Service Recipient's injuries were consistent with her falling to the floor on her right side.

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged. The substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report.

Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 3 act.

Substantiated Category 3 findings of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a

substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to SSL § 496 (2). The report will be sealed after five years.

Allegation 2

The Justice Center contends that on [redacted], the Subject failed to provide adequate services by not following the head injury protocol when a service recipient was found on the floor.

To sustain an allegation of neglect, the Justice Center must prove that the Subject was a custodian who owed a duty to the Service Recipient, that she breached that duty, and that her breach either resulted in or was likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. (SSL § 488(1)(h))

Specifically, the record establishes that prior to the incident the Subject knew of, and had been trained on, the head injury protocol. On the day of the incident, at or about 2:10 p.m., Staff 2 returned the Service Recipient to room #[redacted] and told the Subject that he discovered the Service Recipient unsupervised and sitting on the floor in the hallway outside of the room. The Subject admitted that he did not perform the head injury protocol or conduct a body check of the Service Recipient to assess any potential injuries. The Subject also admitted that he did not contact the nurse nor documented the Service Recipient's elopement.

The record further establishes that under these circumstances, coupled with the facts that the Service Recipient was non-verbal, had no history of engaging in behaviors involving sitting or dropping to the floor and that she had a history of osteoporosis/osteopenia with a Plan of Nursing Supervision (PONS) requiring any falls to be reported to the nurse, it was not unreasonable to have expected the Subject to suspect that the Service Recipient may have fallen and sustained injuries.

Here, the Subject had a duty to conduct the head injury protocol as a part of his body check of the Service Recipient after Staff 2 had returned her to room #[redacted] and reported that he found her sitting on the hallway floor. The Subject breached that duty when he failed to follow the head injury protocol and ensure that the Service Recipient was unharmed during the period she was out of the room unsupervised.

Consequently, the Subject's conduct resulted, or was likely to result in the physical injury or serious or protracted impairment of the physical, mental or emotional condition of the Service Recipient. The Subject's failure to follow the head injury protocol delayed the discovery that the non-verbal Service Recipient had fallen and seriously injured herself. The Subject's conduct further delayed the treatment of the Service Recipient's injuries.

The Subject had raised many assertions, all of which were unpersuasive. The Subject argued that, when Staff 2 returned the Service Recipient, he did not tell him that she had fallen. However, Staff 2 did not observe the Service Recipient fall and he could not report to the Subject what he did not see. Moreover, the Service Recipient was non-verbal; so, she could not tell staff that she had fallen. Most importantly, Staff 2 reported to the Subject that he found the unsupervised Service Recipient out of the room and sitting on the floor, which was reasonably suggestive that she may have fallen and should have alerted the Subject to undertake the proper precautions.

The Subject further claimed that after the Service Recipient was returned to the room and that although he was aware of the head injury protocol, he did not perform the protocol because he was not aware of any injuries. However, this assertion is unpersuasive. Given the circumstances, it was reasonable to have expected the Subject to have taken precautions by conducting a body check and initiating the head injury protocol to assess if there were any signs

and symptoms of a "head/spinal injury/trauma" from an unwitnessed fall. (Justice Center Exhibit 29) This is especially so since the Service Recipient's PONS required all falls to be reported to the nurse due to the Service Recipient's history of osteoporosis/osteopenia. (Justice Center Exhibit 30)

Accordingly, it is determined that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect alleged. The substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated report constitutes the category of neglect set forth in the substantiated report.

Based upon the totality of the circumstances, the evidence presented and the witnesses' statements, it is determined that the substantiated report is properly categorized as a Category 3 act.

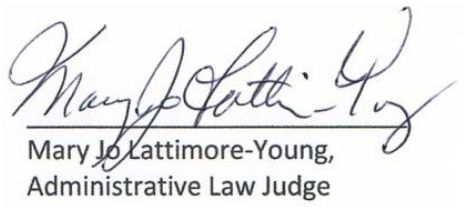
Substantiated Category 3 findings of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to SSL § 496 (2). The report will be sealed after five years.

DECISION: The request of [redacted] that the substantiated report dated [redacted] be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 3 act.

This decision is recommended by Mary Jo Lattimore-Young, Administrative Hearings Unit.

DATED: August 11, 2017
West Seneca, New York



Mary Jo Lattimore-Young,
Administrative Law Judge